

FILED MAY 13 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13990

State File No.

BIRTH NO.		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>3696</u>	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE <u>Illinois</u> b. COUNTY <u>Marion County</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <u>Salem</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>				e. STREET ADDRESS (If rural, give location) <u>217 W. Porter</u> <u>81208</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Kathryn</u> b. (Middle) <u>MMN</u> c. (Last) <u>Walker</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 26, 1955</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED: NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 27, 1886</u>		9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Iuka, Illinois,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Jackson O Piper</u>			13b. MOTHER'S MAIDEN NAME <u>Millie E. Hines</u>		14. NAME OF HUSBAND OR WIFE <u>Herman J. Walker</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u> <u>Nil.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Louise B. Hellmeyer 201 E. 7th St.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u> Pana, Illinois INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> ANTECEDENT CAUSES DUE TO (b) <u>Cerebral Arteriosclerosis</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <u>Diabetes Mellitus</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				5 yrs. 10 yrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR? <u>260X</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>April 19, 1955</u> , to <u>April 26, 1955</u> , that I last saw the deceased alive on <u>April 26, 1955</u> , and that death occurred at <u>3:10 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>C. D. McMillan, M.D.</u> (Degree or title)				23b. ADDRESS <u>BARNES HOSPITAL</u>		23c. DATE SIGNED <u>4/26/55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>4-26-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>East Lawn Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Salem, Ill.</u>	
DATE REC'D BY LOCAL REG. <u>APR 26 1955</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe 4700 Washington.</u>			

S. P. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Robert M. Murray

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.